GERALD R. JERKINS, M.D.
PEDIATRIC UROLOGY ASSOCIATES OF THE MID-SOUTH, P.C.

DATE: _____

PRIMARY CARE PHYSICIAN: _____ Address: _____
Phone #: (____)_____

REFERRING PHYSICIAN: _____ Address: _____
Phone #: (____)_____

Patient's Name: _____ Date of Birth: _____ Sex _____ Race _____

DRUG ALLERGIES: _____ Patient's SS # _____

Responsible Party's Name: _____ S. S. # _____ D.O.B. _____

Address: _____ Phone # (____)_____
(Street) (City) (State) (Zip)

EMERCENCY CONTACT (**NOT PARENTS**) NAME AND PHONE # _____(___)_____

Father's Name: _____ S.S#_____ D.O.B:_____
(Last) (First)

Home Address:_____ Home Phone: (____)_____
(Street) (City) (State) (Zip) Cell Phone: (____)_____

Employment:_____ Address:_____ Work Phone: (____)_____

Mother's Name: _____ S.S#_____ D.O.B:_____
(Last) (First)

Home Address:_____ Home Phone: (____)_____
(Street) (City) (State) (Zip) Cell Phone: (____)_____

Employment:_____ Address:_____ Work Phone: (____)_____

WE APPRECIATE PAYMENT AT THE TIME OF SERVICE
WE ARE UNABLE TO FILE YOUR INSURANCE WITHOUT A COPY OF YOUR CARD

Primary Insurance Co. _____
Insured's Name _____
Address for Claims _____
Insured's S.S. # _____
Subscriber & Group # _____
Phone # _____

Secondary Insurance _____
Insured's Name _____
Address for Claims _____
Insured's S.S. # _____
Subscriber & Group # _____
Phone # _____

AUTHORIZATION

I hereby authorize Gerald R. Jerkins. M.D. to furnish information carriers concerning this treatment and I hereby irrevocably assign to the Doctors all insurance benefits otherwise payable to me but not to exceed the charges shown. I understand that I am financially responsible for all charges not covered by this authorization. I also understand that I am responsible for reasonable collection of this account.

Our Policy is payment at time of service. Billing fees will be assessed after 45 days.

Signed: _____ Relationship to patient _____

MEDICAL HISTORY

Patient Name:_____ Birthdate:_____

Drug Allergies:_____

All information given will remain confidential. Please complete the following.

Reason for Visit/Problem:

_____

_____

Please list any tests/x-rays that have been done regarding this problem.

Date	What was done	Where

Please list all medications patient is taking now.

Medicine	Dosage	Physician	Condition

Please list all surgeries, serious illnesses, and hospitalizations.

Year	Surgery/Illness	Hospital/Location

Is there a family history of:

urinary tract infection	yes_____no_____	please specify_____
reflux	yes_____no_____	please specify_____
other kidney problems	yes_____no_____	please specify_____

OVER

If patient is here for bedwetting:

Is there a family history of bedwetting?	yes_____no_____
Has patient been treated for this before?	yes_____no_____
Ever tried alarm systems?	yes_____no_____
Ever tried medication?	yes_____no_____

How often does patient wet the bed?_____

How long has this been occuring?_____

Does patient have:

daytime wetting accidents?	yes_____no_____
previous urinary tract infections?	yes_____no_____
frequency of urination?	yes_____no_____
painful urination?	yes_____no_____
awakening at night to void?	yes_____no_____

Is there anything else we should know in order to better care of this patient?

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my child's medical status.

Signature(Parent/Guardian)_____Date_____

GERALD R. JERKINS, M.D.

Pediatric Urology Associates of the Mid-South, P.C.
1920 Kirby Parkway, Suite 100
Germantown, TN 38138

Telephone: (901) 751-0500
Toll Free: (877) 751-0500
Fax: (901) 751-0551
www.kidsurology.com

OFFICE POLICY ON MANAGED CARE INSURERS

Gerald Jerkins, M.D., Pediatric Urology Associates of the Mid-South, P.C. has enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employers guidelines and stipulations, we must rely on you, the patient, to inform us each time of service exactly what those guidelines and stipulations are. The patient, parent or guardian is responsible for getting the current information about your insurance coverage. It is your responsibility to make sure we are in network, if not you must obtain out of network approval.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as lab work, screening/preventative care, hospitalization, and/or out-patient procedures that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide.
We want you to receive all of the benefits offered to you.

****

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature Date

****

For office personnel

_____ _____

Witness Date

DR GERALD R. JERKINS
Pediatric Urology Associates of the Mid-South, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
Valid for 5 years or until revoked in writing by the parent/patient.

CHILD'S NAME: _____ PARENT'S NAME: _____

ADDRESS: _____

CHILD'S DATE OF BIRTH: _____

Please answer all statements below by circling Yes or No and Initial by each answer.

YES / NO _____ I GIVE DR. GERALD JERKINS OFFICE PERMISSION TO RELEASE MY RECORDS TO ANY PHYSICIAN, PHARMACY, OR HEALTHCARE FACILITY THAT HAS ASSISTED IN MY CARE.

By listing a Physician(s) below this is the only Physician(s) I give permission to have medical records released to: **(If no physician listed below records can be released to any needed)**

_____

_____

_____

YES / NO _____ I GIVE DR. GERALD JERKINS OFFICE PERMISSION TO OBTAIN MY RECORDS FROM ANY PHYSICIAN, PHARMACY, OR HEALTHCARE FACILITY THAT HAS ASSISTED IN MY CARE.

YES / NO _____ I GIVE MY PERMISSION FOR MESSAGES TO BE LEFT ON MY ANSWERING MACHINE OR VOICE MAIL SYSTEM REGARDING:
TEST AND/OR LAB RESULTS AND/OR APPOINTMENTS.

YES / NO _____ I GIVE MY PERMISSION FOR MESSAGES TO BE LEFT WITH A FAMILY MEMBER OR OTHER PERSON AT MY HOME. PLEASE LIST SPECIFIC NAMES:

_____

I HAVE ANWSERED YES OR NO AND INITIALED BESIDE ALL STATEMENTS ABOVE

PARENT'S SIGNATURE: _____ DATE: _____

****

For Office personnel to sign below

WITNESS SIGNATURE: _____ DATE: _____

PEDIATRIC UROLOGY ASSOCIATES OF THE MID-SOUTH, P.C.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- *Health oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order.

- *Law enforcement purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.
- *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious threat to health or safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- *Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- *Research:* We may use or disclose information for approved medical research.
- *Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Name: Gerald R. Jerkins, M.D.
Title: Chief Manager
Address: 1920 Kirby Parkway, #102
Phone Number: 901.751.0500

Effective Date: The effective date of this Notice is April 14,2003.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I,_____hereby acknowledge receipt of the Notice of Privacy Practices given to me by Pediatric Urology Associates of the Mid-South, P.C.

Signed:_____Date:_____

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For Office Use Only:

If not signed reason why acknowledgment was not obtained:_____

_____

Person seeking acknowledgment:_____Date:_____